Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAN ANTONIO SPINE AND REHAB

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-11-0238-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 15, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This treatment was deemed medically necessary through preauthorization. On 02/26/2010. [sic] CPT codes 97110-GP, G0283-GP, 97140-GP, 97140-GP [sic] was authorized, authorization number 100226xxxxxx. Start date February 26, 2010 to be completed by April 26, 2010. . . Please review and forward payment. . . ."

Amount in Dispute: $1,049.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves DOS 03/29/10 through 04/01/10. Carrier is re-auditing the bill at this time and hopes to have the after resolved."

Response Submitted by: FLAHIVE, OGDEN & LATSON

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2010 through April 7, 2010	97110x 4 units, G0283, 97140 and 99213	$1,049.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 283 – Based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary.
   - W1 – Workers compensation state fee schedule adjustment.
   - No allowance change.

Issues

1. Did the insurance carrier issue payment for the disputed charges?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the insurance carrier's documentation supports that the insurance carrier issued a payment in the amount of $957.73 for disputed dates of service March 29, 2010 through April 7, 2010, payment number 1883986099. The requestor seeks a total amount of $1,049.92. The division will calculate the reimbursement for each disputed CPT code to determine if additional reimbursement is due to the requestor.
2. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 97110 is $41.87 x 4 units = $167.48 for dates of service March 29, 2010, March 31, 2010 and April 1, 2010 = a total recommended amount of $502.44.

   The MAR reimbursement for CPT code 97140 is $39.25 x 2 units = $78.50 for dates of service March 29, 2010 March 31, 2010, and April 1, 2010 = a total recommended amount of $235.50.

   The MAR reimbursement for CPT code G0283 is $17.51 for dates of service March 29, 2010 March 31, 2010, and April 1, 2010 = a total recommended amount of $52.53.

   The MAR reimbursement for CPT code 99213 is $95.92 for date of service April 7, 2010.

   The requestor is entitled to a total recommended amount of $886.39. The Respondent submitted sufficient evidence to support that the insurance carrier issued a payment in the amount of $957.73. Therefore no additional reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.